HEALTH OVERVIEW AND SCRUTINY PANEL
19 AUGUST 2013
2.10 - 3.50 PM

Bracknell Forest Council

Present:
Councillors Virgo (Chairman), Mrs McCracken (Vice-Chairman), Mrs Angell, Baily, Finch, Thompson and Brossard (Substitute)

Apologies for absence were received from:
Councillor Kensall

Also Present:
Councillor Birch, Executive Member for Adult Social Care, Health & Housing
Councillor Leake, Chairman of the Overview & Scrutiny Commission
Glyn Jones, Director of Adult Social Care, Health & Housing
Jessica Zeff, Care Quality Commission
Tracy Halladey, Care Quality Commission
Mike O'Donovan, Chairman of Heatherwood & Wexham Park NHS Trust
Grant McDonald, Deputy Chief Executive, Heatherwood & Wexham Park NHS Trust
Dr Rob Loveland, Medical Director, Heatherwood & Wexham Park NHS Trust
Richard Beaumont, Head of Overview and Scrutiny

14. **Minutes and Matters Arising**

The minutes of the Panel held on 11 July 2013 were approved as a correct record and signed by the Chairman.

Matters Arising:

Minute 3: Matters Arising: Shaping the Future Consultation
It was reported that the application for judicial review made by the Royal Borough of Windsor and Maidenhead (RBWM) had been rejected and RBWM had decided not to pursue this course of action any further.

15. **Declarations of Interest and Party Whip**

There were no declarations of interest.

16. **Urgent Items of Business**

There were no items of urgent business.

17. **Public Participation**

There were no submissions from members of the public.

18. **Heatherwood and Wexham Park Hospitals**

The Panel considered the report before them which detailed the actions planned by Heatherwood and Wexham Park Hospitals NHS Foundation Trust in response to the inspection reports issued on both hospitals by the Care Quality Commission.

The Chairman welcomed the following health partners to the meeting:

Jessica Zeff, Care Quality Commission (CQC)
Tracy Halladey, Care Quality Commission
Mike O'Donovan, Chairman, Heatherwood & Wexham Park NHS Trust (HWPT)
Grant McDonald, Deputy Chief Executive, HWPT
Dr Rob Loveland, Medical Director, HWPT

The Chairman invited representatives from the CQC to comment on the inspection report and subsequent action plan drafted by HWPT (the Trust). The Compliance Inspector from the CQC stated that the Trust had taken the inspection report very seriously and had produced an action plan that was being closely monitored by a range of stakeholders.

The Chairman asked representatives from the Trust if they had been surprised by the findings in the inspection report or what their feelings had been to the inspection report.

The Chairman of the Trust stated that he had been distressed by the findings as the Trust was not delivering what they wanted to deliver for patients. There were a good number of examples where a good patient experience was not being delivered. Over the last winter the Trust had faced record levels of demand and they had struggled to meet this demand. The position of the Trust almost became one of 'some care was better than no care'. This was being carefully considered for the upcoming winter to ensure that the Trust had the right capacity to meet demand.

He reported that it was frustrating that the Trust had scored a number of 'own goals' where they weren't doing things as well as they should and which were fixable. The Trust's governance arrangements were being reviewed and the inspection report was being used as a means of shocking people into doing things better. The Trust had taken on board all the findings of the inspection report and did not dispute any of them.

The Panel asked if the Trust's Board had taken an active interest in the operation of the Trust and the level of priority given by the Board to this.

The Trust's Chairman reported that he recognised that the Board needed to be more forthright about the speed at which changes and improvements were being made. Lots of things were in train but were not being done quickly enough. He recognised that the Board needed to be more focussed on what was going on at ward level and needed a more granular breakdown of issues. The Board was changing the way in which information was fed to the Board as it was clear that the Board wasn't getting the quality or picture of information it required.

The Panel asked if the inspection report had surprised members of the Board.

The Trust's Deputy Chief Executive stated that he worked hard to know what was happening throughout the Trust and whilst there were a number of things that they were aware of and were already working on and trying to change, there were a number of issues that had been highlighted by the inspection report which they had not been aware were as bad as they were.

He stated that he had felt frustrated and upset by the inspection report but recognised that it was important to move forward and make things different.

The Panel recognised that the Chief Executive of the Trust had an open door policy and questioned whether there was a culture problem at the Trust.

The Trust's Deputy Chief Executive agreed there was a culture problem and stated that there was a problem around staff attitude and behaviours. This had been demonstrated by the CQC's inspection report and was an area of real concern for the Trust. 75% of the Trust's action plan detailed action that could be taken to change practices and embed them; changing staff behaviour and attitudes would be much more challenging. Work around helping staff to replicate attitudes and behaviours would be necessary and where issues remained action would be taken. In addition, a compliance check regime had been introduced to improve day to day checking.

The Panel asked if the Trust were happy with their action plan.

The Trust's Deputy Chief Executive stated that this was the first phase of the action plan which involved taking immediate action to fix issues. Work around underlying cultural issues would require a much more comprehensive piece of work. The action plan was incomplete, the Trust would need to define clearly to staff how culture needed to be changed. Lines of responsibility and accountability also needed to be better defined. A robust system of measure needed to be in place and the Trust needed to be stronger at enforcing and implementing change.

The Trust's Medical Director stated that the Trust had undergone many changes in management and many Chief Executives and this had impacted the organisation. The Trust had become slightly blinded as to their focus and the CQC inspection report had brought back this focus. The culture of 'do not walk by' needed to be embedded into the mindset of all staff. The idea being that all staff had a corporate responsibility. It was reported that when matrons were informed of the findings of the inspection report there was a look of shame among them and this was certainly a positive response.

The Chairman then asked that the Panel move to the consideration of the Trust's action plan.

The Panel queried action 1.3 and asked Trust representatives to clarify the purpose of this action

It was reported that this action was intended to enhance direct nursing and as a result embed ownership and move away from shared responsibility. An appointment had already been made to this position and the staffing structure had been clarified.

The Panel asked about action 1.4, which included the closure of a number of services.

The Trust's Deputy Chief Executive stated that this was necessary as a range of measures to provide a more effective service.

The Panel felt perturbed that patients were waiting for up to 11 hours in A&E, in addition, that in the Dementia area and Stroke services there appeared to be a lack of communication, patients were being ignored. Call bells were described as defective or not working.

The Trust's Deputy Chief Executive stated that call bells were now all working. Daily compliance checks would monitor if nurses were responding to call bells. On average the Trust had 300 people daily entering A&E. The Trust was attempting to make the physical footprint of A&E larger so that patient privacy and dignity could be improved as well as patient waiting times. The long waiting times in A&E were created by a combination of factors, any delay in discharging patients had a knock on effect throughout the hospital and to A&E. Internal discharge procedures were being reviewed to see how they could be improved. The Trust recognised that 11 hour waiting times were unacceptable. In July, the Trust had achieved its target of 95% of A&E patients waiting less than four hours for treatment.

The Medical Director complimented the Council's adult social care interface with the Trust. The Director of Adult Social Care, Health and Housing commented that the local authority arrangements regarding hospital discharge varied from council to council.

The Panel queried consultant costs detailed at 4.1 of the Trust's action plan.

The Trust's Deputy Chief Executive stated that they needed the skills of an expert in healthcare modelling to undertake complex financial analysis. It was a highly technical piece of work and these kind of skills were not available within the staffing of the Trust.

The Panel asked the extent to which patients were being streamed into urgent care.

The Trust's Deputy Chief Executive stated that the urgent care centre was GP manager led and patients would be directed to this centre immediately before or after A&E. The Trust were working to enhance the process for patients who arrived at hospital in an ambulance. The Trust were looking at patients being immediately being seen by a consultant or doctor to assess their needs. It was recognised that the Trust would need appropriately skilled staff and an appropriate model of care to achieve this.

The Panel stated that the triage system used by Frimley Park and Royal Berkshire used before patients were admitted to A&E seemed to work very successfully, and asked whether this was a model the Trust could consider.

The Trust's Deputy Chief Executive stated that the Trust already used a triage system; more clarity was needed around as to how it could be more effectively used. The consultant would undertake this work.

The Panel asked how the Trust felt that the dedicated Chief Executive email detailed in 4.15 of the action plan may improve whistle blowing.

The Trust's Deputy Chief Executive stated that this would improve communication channels and give frontline staff a range of ways to report things that concerned them.

The Panel were concerned that despite there being systems in place to deal with infection control, these had not been complied with. The Committee asked for assurance that new systems would ensure staff compliance.

The Chairman of the Trust stated that, for illustration, the responsibility to keep wards clean had previously been with the cleaner, meaning that non-compliance was not always actioned. This responsibility was now held jointly by the ward matron. This would mean that the person in charge of a ward would also be responsible for its

cleanliness. A system of deep cleansing was also being introduced. Weekly meetings were also being held with the infection control team. Where patient safety was threatened, the Board would be given almost instant sight of this issue.

The Panel referred to page 17 of the agenda papers which described a failure in medicine management, giving the example of a confused elderly patient who was regularly hiding his pills in his bedding and asked how the responsibilities of matrons could be monitored.

The Deputy Chief Executive stated that the Trust had a small compliance team who would be regularly checking paperwork on wards to check on the work of the matrons and noting any non compliance. Board members would also be undertaking these checks.

The Panel asked that if family members continued to find pills in patient bedding, how should this be reported.

The Trust's Deputy Chief Executive stated that this could be reported to the CQC, himself or the Chief Executive.

The Panel asked if the use of temporary staff could prevent relationships being forged with patients.

The Trust's Deputy Chief Executive reported that often the temporary staff used by the Trust were often Trust staff who were working extra shifts. In any event, nurses should be signing off paperwork to show what medication had been taken by the patient. It was noted that most patients stayed on average for a period of four or five days and so relationships were limited.

The Trust's Medical Director stated that the cost and quality of temporary staff was an ongoing concern for the Trust. The Trust struggled to attract people to their nursing vacancies and were as a result forced to them employ temporary staff. The Trust's position at the edge of London made it very difficult to recruit and retain staff. Increased demand in some areas also exacerbated staff shortage issues.

The CQC's Compliance Inspector reported that she recognised that the Trust had made a huge effort to recruit staff. She also recognised that staff worked incredibly hard to cover shifts and took on extra shifts to ensure there were not staff shortages on wards. She recognised that staff were taken from other wards to manage increased demand in some areas; however there still remained long term staff shortages in a number of areas which was a concern.

The Trust's Deputy Chief Executive stated that they did all they could to recruit however it would always be the case that some people preferred to work on a temporary basis with an agency. The Trust's Chairman stated that the Trust's strategic objectives included reducing the reliance on agency staff; this would link to reducing their overall deficit.

The Panel referred to page 106 of the agenda papers that detailed the responses from Trust staff to say whether they would recommend services of the Trust to their family and friends. 49% of staff in 2012 had said that they wouldn't recommend the hospital to family and friends.

The Trust's Deputy Chief Executive stated that this again pointed to the culture in the Trust and resources and support would need to be put into improving the culture among staff. He stated that Heatherwood's responses from staff had been a little

more favourable and this was likely to be as a result of the way in which urgent care was provided there.

The Panel asked if the Board received a full list of all complaints.

The Trust's Chairman reported that each Board meeting received all complaints and that they were categorised to assist with tackling them. The Board received a qualified list and if they wanted more information they could request this. He recognised that the Trust needed to get better with the time it took to respond to complaints.

He also stated that the Board needed to be more inquisitive and forensic when considering complaints. The Trust Board also needed to be better at checking that processes had been reviewed and desired outcomes achieved as a result of this. An audit of outcomes was necessary.

The Panel noted that there were clearly issues around the culture at the Trust, they asked if this impacted record keeping.

The Trust's Deputy Chief Executive stated that the quality of notes taken by nursing staff were often a reflection of how much staff cared about the patient. Notes were not simply a record, they were used to handover to staff so that they knew what the patients needs were.

The Panel asked if the staff were being asked to do too much.

The Trust's Deputy Chief Executive recognised that this could sometimes be the case however he couldn't see why records were not adequately kept despite this.

The Executive Member for Adult Social Care, Health & Housing stated that if the Council saw surges in demand in a particular service area, it was forced to take funding from elsewhere to meet this demand. How would the Trust be funding the implementation of their action plan and how would this impact the Trust's deficit.

The Trust's Deputy Chief Executive stated that much of the Trust's spend was already allocated to capital and this had been in place before the CQC's inspection report. He was confident that if the Trust started doing things properly, this should not cost more. He stated that he felt that the initial action plan would have little or no cost implications and that greater efficiencies should lead to cost savings.

The Trust's Medical Director stated that the Trust experienced one of the highest number of A&E patients coming through the door than anywhere else in the country. The Trust's front door was always open but there were finite resources. Surges in demand would inevitably impact elective work and there were all sorts of financial implications tied to this.

The Panel asked whether the inspection report had been circulated or communicated to staff.

The Trust's Deputy Chief Executive stated that the report had been communicated in a range of ways; at team briefings and staff had been written to before the report had been published. There had also been face to face meetings and interactive responses.

The Executive Member for Adult Social Care Health & Housing stated that he was keen to support the Trust with their action plan. The Council would like to play a role

in ensuring the action plan was brought about and to help the Trust by constructively holding them to account. He looked forward to the Panel working with the Trust and seeing them progress and building a relationship with the Trust.

The Panel thanked all health partners for their candour and recognised that there must have been a certain amount of personal reflection among Board members as to how the Trust had reached the position it was in. It was clear that the Trust faced cultural issues as well as substantial governance issues which would need to be addressed. Many of the things detailed in the CQC's inspection report were found through simple observation and by walking around the wards. These things therefore must also have been seen by nurses, matrons, consultants and managers but yet were not tackled. This clearly demonstrated issues around personal responsibility and accountability and the need for staff to recognise that they were all working for the same team.

The Chairman concluded the meeting by thanking health partners for their candour, honesty and for their attendance. He was very pleased to have received the Trust's action plan as this was a first step towards improving practices, there was clearly a lot more work to do, and the Panel was fully supportive of the Trust's efforts. He encouraged the Trust to give greater priority to staff and patients and to take staff with them when implementing the action plan. He stated that it was important to recognise that there was also lots of good services at Wexham Park and this shouldn't be forgotten.

He stated that he would like to invite health partners back to the O&S Panel to be held on 7 January to report on progress with the action plan and any other work undertaken to improve practices.

19. **Date of Next Meeting**

3 October 2013

CHAIRMAN